DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-042047

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9328

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b: 26 days	c. CITY OR TOWN Spanish Lake — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital — Inside Limits: Yes ☑ No ☐	d. STREET ADDRESS (If outside, give location) 1016 Prigge Road — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print)	First: ANNA	Middle: M.	Last: JONES	4. DATE OF DEATH	Month: Oct.	Day: 10	Year: 1959
5. SEX: Female	6. COLOR OR RACE: White	7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐	8. DATE OF BIRTH: Oct.27,1892	9. AGE (last birthday): 66	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HR: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (City and state or country): E.St. Louis, Illinois	12. CITIZEN OF WHAT COUNTRY: USA				
13a. FATHER'S NAME: George Sutter	13b. MOTHER'S MAIDEN NAME: Unknown	14. NAME OF HUSBAND OR WIFE: Thomas L.Jones (deceased)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): –	16. SOCIAL SECURITY NO.: 486-14-7657D	17. INFORMANT: Mr.Billy Jones — Address: 1016 Prigge Road, Spanish Lake MO.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PULMONARY EMBOLISM	IMMEDIATE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. — DUE TO (b)	THROMBUS - PELVIC VEINS	UNKNOWN
DUE TO (c)	466X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from September 15 '59 to October 10 '59 and last saw her/him alive on October 10 '59

Death occurred at 10 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD — 22b. ADDRESS 3701 Grandel Sq St Louis — 22c. DATE SIGNED 10-12-59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	Oct.13,1959	Friedans Cemetery	St. Louis, MO.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
SUEDMEYER & SON'S	3934 N. 20th St.	10-12-1959	Hoard Smith, M.D. M.D.B.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

~~Student~~ _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4283

P. O. Address St. Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.